MMS

Patient Registration

Last Name: _____ First Name: _____

Social Security #: _____ Date of Birth: _____ Marital Status: S M W D

Address: _____

Street/ P.O. Box City State Zip Code

Home Phone: _____ Cell Phone: _____ Email Address: _____

Whom may we thank for referring you: _____

Employer Information: _____ Phone Number: _____

Responsible Party (person responsible for the payment today and after insurance payment (if any):

Name: _____ Phone Number: _____

Address: _____

Date of Birth: _____ SS#: _____ Relationship to patient: _____

Employer: _____ Work Phone: _____

Emergency Contact: Name: _____ Phone Number: _____

Relationship to patient: _____

Insurance Information: Primary Company Name: _____ Policy #: _____

Secondary Company Name: _____ Policy #: _____

Please initial each statement in space provided, then sign full signature and date at bottom of page. Thank you

_____ **Medical Consent**: I consent to the examination, treatment and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

_____ **Financial Policy:** Payment of deductibles and copayments are expected at the time of services. Cash and Cred/Debit Cards (excluding American Express) are acceptable methods of payment. Insurance claims each service date will be submitted to your insurance company twice, after which time the responsibility for payment will become yours.

_____ **Notice of Patient Privacy Practices:** By signing this written acknowledgment of receipt of Mountaineer Medical Services PLLC Notice of Patient Privacy Practices, I hereby expressly acknowledge my receipt of Mountaineer Medical Services PLLC Notice of Patient Privacy Practices.

_____ **Notice of Billing From an Outside Laboratory:** Laboratory testing may be necessary as part of your medical services. If the provider or you yourself request laboratory testing, you will receive a separate bill from the lab performing the testing. The billing and any other questions with regards to laboratory services are to be addressed directly to the lab. Please initial and sign below attesting to your knowledge and acceptance of this policy.

Patient or Legal Representative----- Signature: _____ Date: _____

Reason's for today's visit:

_____

_____

_____

Please list any medication you are currently taking:

_____

_____

_____

_____

PAYMENTS & POLICIES

Insurance: We participate with most insurance plans, including Medicare. If you are not covered by insurance we will be glad to provide medical care for you, but payment is expected in full at time of visit. ***_Knowing your insurance benefits is your responsibility. Please contact your insurance company for any questions you may have regarding coverage and benefits._***

HIPPA: In accordance with HIPPA guidelines our office will not divulge any personal or medical information to outside parties unless explicitly instructed to do so by the patient. If you have a spouse, caretaker, or relative you would like information to be freely shared with please fill out a release of information form and/or please provide us with their name here

_____

Copayments & Deductibles: all copayments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure to collect copayments and deductibles can be considered fraud.

Change of Contact Information: It is the patient's responsibility to keep our office up to date with contact information. Change in phone number or mailing address is to be reported to our office as soon as possible. MMS will not be held responsible for miscommunication due to out of date contact information.

Non-Covered Services: Please be advised that some and perhaps all of the services rendered may or may not be covered by your insurance company. You are responsible for these charges.

Proof of Insurance: All patients must provide a copy of a VALID insurance card.

Claims Submission: We will submit your claims and assist any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claims or not. Your insurance benefit is a contract between you and your insurance company; we are not the party to that contract.

Coverage Changes: Please notify our staff of if there are changes to your insurance plan. If your company does not pay the claim within 45 days you will be billed directly.

Missed Appointments: Without 24 hour notice, you will be charged for any missed appointment. These charges will be your responsibility and billed directly to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for this area.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE PAYMENT AND POLICY AGREEMENT AND AGREE TO ABIDE BY ITS GUIDELINES.

Signature of Patient or Responsible Party:_____**Date:** _____